Commonwealth of Massachusetts
HOUSE OF REPRESENTATIVES

HPAO

HOUSE POST AUDIT
AND
OVERSIGHT BUREAU

ROOM 146 • STATE HOUSE • BOSTON, MASSACHUSETTS 02133-1053

The Department of Mental Retardation

Preliminary Report
December, 1994

THIS REPORT WAS PREPARED AND ISSUED UNDER THE MANDATES OF MASSACHUSETTS GENERAL LAW, CHAPTER 3, SECTIONS 63 AND 64.

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BUREAU DIRECTOR/GENERAL COUNSEL
Thomas W. Hammond, Jr.

FINDINGS

1. The Bureau finds the most recent attempt by the state Department of Mental Retardation (DMR) to monitor its clients is ineffective. The Bureau does not find that the new Quality Enhancement Survey Tool (QUEST) is sufficient to successfully monitor services and ensure the quality of care. Quality monitoring was the objective of 20 years of court supervision of DMR. The oversight of quality is intended to protect against client abuse, negligence, and death. The lack of uniformity in the Quest survey tool, the apparent low number of sites actually visited compared to the stated and projected goal of DMR (263 sites visited compared to the 1994 goal of 1502 sites evaluated), and the large number of providers serving DMR clients who require monitoring, increase the Bureau's doubts about the effectiveness of recent quality control efforts.

2. In addition to the validity of monitoring measures, the Bureau is concerned with the amount and adequacy of quality control follow-up inspections, and internal investigation of complaints.

3. The Bureau finds that the Quest tool's monitoring and oversight deficiencies are aggravated by the current system of providing services. The Bureau finds that the functional changes at DMR, from centralized institutions to a decentralized system of multiple providers and numerous facility sites, raise serious and significant concerns about long term costs and quality. A detailed inquiry is warranted, particularly with regard to appropriate oversight of the health, happiness, and safety of the mentally retarded citizens of Massachusetts.

4. Despite the disengagement order and the reorganization of the quality assurance component, recent cases of abuse, and death at DMR facilities highlight the problems of oversight and effective monitoring.

5. The new quality assurance mechanisms do not appear to adequately identify problem areas that lead ultimately to cases of abuse and investigations. A review of several investigations highlighted problems not only with oversight and quality assurance, but also with DMR's internal investigative unit. The Bureau finds substantial support for the idea that the DMR Investigation's Unit should be made a separate unit in some other agency.

Quality Control and "Quest"

Program quality is a vital part of all services. In 1993, the Department of Mental Retardation (DMR) restructured its quality control process to "promote the provision of the highest quality services" for DMR consumers. The new system was intended to enhance the quality of care received by DMR clients. The restructured quality control system combined licensing, quality assurance, and human rights divisions into one office, the Office of Quality Enhancement (OQE). Quality Enhancement focuses on "what occurs for the individual as being the most important measure of quality."[1]

About the same time the DMR quality control system was restructured, DMR designed a comprehensive quality control vendor evaluation survey - "one tool [to] measure the impact of services on the quality of life of the individuals." This single, comprehensive tool is known at DMR as the Quality Enhancement Survey Tool (QUEST).

The Quest survey was tested throughout 1993 and implemented in January, 1994. This new survey tool replaces the former DMR licensing process with a "certification" process.

The certification process "will incorporate current procedures - licensing certification (annual), Human Services home visits (annual), Family/Citizen Monitoring (every five years) and Quality Assurance Program Evaluations (every five years) - into one annual QUALITY SURVEY (sic) visit conducted by a team of OQE surveyors, consumers and family/citizen members. The focus of the survey will be on the individual as opposed to the 'program' or

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1 "Survey and Certification Procedures Manual, Department of Mental Retardation, Executive Office of Health and Human Services, Commonwealth of Massachusetts, January, 1994, pg. 3."

site of services. The survey will sample 35 percent of the individuals served annually," according to documents supplied under subpoena to the Bureau, entitled "Quest Materials" and dated August 30, 1994. (During a presentation to the Bureau, DMR indicated that the sample size is currently 25 percent rather than the 35 percent as quoted in the certification process.)

The DMR certification process qualifies each provider, whereas the former DMR licensing process verified the physical appropriateness of individual sites. The new system "evaluates quality based on the consumers' satisfaction with the quality of their supports," according to the DMR procedures manual. (See Footnote #1)

Background

The concerns about quality of care and court involvement regarding the mentally retarded, occurred almost simultaneously in Massachusetts. As the documents referenced earlier and dated August 30, 1994 state:

> **"[The] first phase of quality assurance monitoring began about the same time as the Massachusetts' consent decrees (1972-1977) and reflected a primary focus on quality control, that is concern for the health, safety and human rights of persons served for the most part, in public residential facilities. This phase culminated with the first set of Title XIX (of the federal Social Security Act) regulations for Intermediate Care Facilities for the Mentally Retarded (ICF/MR)."**

Federal court involvement with the Massachusetts state schools began in 1972. The initial litigation involved the Belchertown State School but was followed by litigation involving other state schools at Monson, Wrentham and Dever. As a result of this litigation, the U.S. District Court supervised the operation of DMR (which was formally a component of the state department of Mental Health) for 20 years.

In 1986 the General Court recognized that the needs, care and treatment of the mentally retarded differed significantly from those of the mentally ill. The mentally retarded citizens of Massachusetts were more appropriately served by a distinct department. The Massachusetts Department of Mental Retardation (DMR) was created by Chapter 599 of the Acts of 1986.[2]

DMR provides residential, day support, and transportation services to approximately 21,000 individuals with mental retardation in the Commonwealth. DMR operates with one of the largest appropriations of any state agency in the Commonwealth. DMR's FY'95 appropriation is $704,133,637 (Chapter 60 of the Acts of 1994).

Care for the mentally retarded within the community rather than at large institutions has been the goal of some advocates since the early 1950s. This issue has dominated public debate regarding care for both the mentally ill and mentally retarded in Massachusetts as well as in numerous other states. [3]

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2 Chapter 599 became M.G.L. c. 19B which provides that "[t]he department shall take cognizance of all matters affecting the welfare of the mentally retarded citizens of the Commonwealth." Under the provisions of this statute, DMR has supervision and control of all facilities for mentally retarded persons.

3 This Bureau report focuses on the mentally retarded, not the mentally ill. The Bureau does not dispute the validity of appropriate community placements. What is of concern to the Bureau is that from an oversight perspective such a fragmented approach to service cannot achieve economies of scale. Moreover, this system with such a large and highly demanding client base makes oversight more not less difficult.

Since it became a distinct department within the Executive Office of Health and Human Services (EOHHS) the DMR has substantially altered its service delivery system for adults with mental retardation. The new system moves DMR clients from state operated institutions serving large populations at single complexes into decentralized, smaller community residences, according to the Governor's Budget.[4] The change from a centralized system of limited locations to a decentralized, multiple site system for services to the mentally retarded is almost complete.

Against the backdrop of a major effort toward decentralization, quality of care has become the focal point of court review. On 25 May 1993 "a United States District Court judge signed the final order vacating the Consent Decree that governed care in Department of Mental Retardation institutions for 20 years. DMR resumed full control of providing ...essential services (to its clients). In compliance with the U.S. District Court final order Governor Weld established a new Commission for Mental Retardation to assist DMR in the post-consent decree era, to ensure that the highest quality of services are provided to DMR consumers and to sustain the Department's mission...," according to the narrative accompanying the Governor's FY 1995 Budget.[5]

The federal court's final order also required a document known as an individual service plan (ISP) for each DMR client, as well as monitoring and safeguards for the mentally retarded.

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[4] House Bill 1, (FY'95)

[5] Please see Appendix, DPPC Governor's Commission

Court Disengagement and Final Order

The protracted litigation involving the state schools reached a tentative resolution with the issuance of the disengagement order in the case of **Ricci, et al. v. R.L. Okin**. That order was signed on May 25, 1993. The disengagement order replaced and supplanted all prior orders and consent decrees. The disengagement order required that services provided by DMR to each class member be set forth in an Individual Service Plan ("ISP"). The order required that any changes in the service plan be submitted to plaintiff's counsel. The order further provided:

> **"that sufficient, adequately trained, and experienced personnel be available to meet the needs of each member of the protected class ISP and, that, among other things, no class member would be transferred out of a state school into the community or from one community residence to another unless it was certified that the member would receive equal or better services."**

Results of Disengagement

The disengagement order established criteria and service levels for all members of the affected class of plaintiffs. The May 25, 1993 court order took effect on the following basis:

> **'8. This order shall take effect upon written notification to the court by the Governor that he has issued the Executive order set forth in Appendix A, which is attached hereto and incorporated herein, and that all members of the Governor's**

Commission on Mental Retardation have been sworn and the Administrator has been appointed.[6] The Advisory Panel of the Office of Quality Assurance shall submit its list of Commission members nominees to the Governor within 30 days of the signing of this Order."

"9. Defendants shall place the following information describing the rights and services under this Order in the permanent record of each class member, shall retain such information on record for so long as the class member is alive, and shall seek to enter such information in the class member's file maintained by all providers of services to class members (and, within one year, by contract require such entry by providers):

a. designation of class membership;
b. notation that class membership results in rights and services guaranteed by this Order, and a summary of those rights; and
c. the name, address and telephone number of plaintiff's counsel, various advocacy organizations, the Department of Mental Retardation, and the Governor's Commission."

This disengagement order effectively ended twenty (20) years of court involvement regarding the quality and oversight of services provided to the mentally retarded. After the

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6 Once this Order takes effect, the Office of Quality Assurance shall limit its activities to those necessary to transfer its files to the Governor's Commission. It is understood that the Office shall cease all operations upon appointment of the Administrator of the Commission, or on June 30, 1993, whichever event later occurs.

issuance of this order, it was the court's decree that the Commonwealth, now the DMR, would provide the necessary services to the mentally retarded by means of the Individual Service Plan (ISP). The Bureau believes that the court's mandates as clearly set forth in the disengagement order have not been followed. As evidence, the Bureau notes the following:

1. The quality assurance program adopted by DMR fails to adequately address the ISP process and the disengagement order;

2. The Department has failed to meet the court mandated requirement that transfers of clients be prohibited unless it was certified that the client receive equal or better services;

3. The Department has failed to meet the goal of providing sufficient numbers of adequately trained and experienced personnel to meet the needs of the clients covered by the decree; and

4. Recent and continuing news accounts chronicle problems of substandard care and abuse. For example, problems of adequate care and staffing have again surfaced at the Fernald State School.

Report of the Inspector General Regarding Investigations

While the provision of quality of care required court oversight, the detection and investigation of abuse and neglect has been hampered by bureaucratic meddling. DMR has long been plagued by problems of abuse and the failure to report abuse. In addition, the Department's failure to meet the mandates of the court decree is further highlighted by examinations of the Investigation's Division of DMR.

Ironically, the disengagement order came shortly after a highly critical report issued by the state Inspector General (IG) in November 1992. The Inspector General issued a "Critical

Review of the DMR Investigations Division.". The IG's report contained the following findings:

1. DMR lacks a uniform rigorous procedure for screening complaints;

2. DMR investigations have been rendered ineffective by mismanagement of the Investigations Division;

3. DMR investigators lacked sufficient training in investigative techniques;

4. DMR lacked an updated agency specific investigations manual;

5. DMR investigators were hindered by interference from regional management;

6. DMR investigative policies lacked consistency and direction;

7. DMR investigation administrators failed to understand the nature of their mandate;

8. DMR investigators had been threatened after speaking to the Inspector General's office;

9. The DMR public logs revealed that abuse was not reported to law enforcement authorities in all instances;

10. DMR investigators lacked uniform access to CORI information; and

11. DMR hiring procedures failed to filter out applicants with disturbing criminal histories.

In reviewing the findings of the Inspector General in conjunction with its own inquiry into DMR monitoring and investigative procedures, the House Post Audit and Oversight (HPAO) Bureau repeatedly found evidence that many of the issues and deficiencies presented in the Inspector General's report remain, and, in some cases, appear to have worsened. It is the contention of the HPAO Bureau that these continuing inadequacies are another factor that jeopardize the quality of service provided to the mentally retarded citizens of the Commonwealth.

Evolution of Quality of Care Measures and Survey Tools.

The integrity of quality control relies on oversight. The HPAO Bureau is also concerned with the appropriateness of the monitoring -- both of the quality of care and of the safety of the DMR clients. Monitoring of the DMR system has most recently undergone a substantial and comprehensive methodological change.

There have been three distinct phases of quality controls within the mental retardation service delivery system: phase one, concerned fire, safety, and health issues; phase two, involved process issues and program objectives related to compliance with Title XIX of the Social Security Act; and phase three, the current phase, regards the client as customer in a human services adaptation of the business management view of quality control, according to a presentation made to the HPAO Bureau by DMR senior management.

As part of the DMR presentation the HPAO Bureau was given a list of recent quality assurance, quality control, or quality enhancement procedures. These included: state quality assurance review of residential, day, and respite; self-evaluation/internal quality assurance; consumer satisfaction survey; individual service plan; accreditation/certification; licensing; service coordinator monitoring; human rights committees; investigations; incident reporting; independent professional review; Title XIX survey; monitor for the mental retardation consent decree; and public entities (building inspectors, fire marshalls, etc.).[7]

DMR documents distributed at a presentation for the Bureau contend that "there is no empirical research linking positive outcomes in the lives of individuals served with specific

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[7] This recapitulation of former and current quality assurance measures was provided to the Bureau by the DMR assistant commissioner for quality enhancement.

quality assurance or monitoring methodologies or combinations of methodologies."

Prior to 1994, DMR consumer services were monitored by the Office of Quality Assurance. Yet "gaps in quality assurance" (See Footnote #1) existed and therefore caused a move to ensure that quality services were being delivered to the consumers. The new system, QUEST, "evaluates quality based on the consumers' satisfaction with the quality of their supports." (See Footnote #1)

Under QUEST, DMR's Licensing, Quality Assurance and Human Rights Division were restructured into the Office for Quality Enhancement ("OQE") in 1993. According to DMR documentation, "OQE is a new certification system which replaces licensing and program evaluation with a unified process which uses a single (our emphasis) tool called QUEST." As of January, 1994 the QUEST tool replaced licensing with certification.

QUEST Survey Fails to Achieve its Evaluation Goals

The Bureau subpoenaed and reviewed all completed QUEST surveys provided by DMR as of November 14, 1994. As of this date DMR supplied 39 completed vendor surveys to the Bureau. After tallying the sites operated by the 39 vendors as best as possible - since some of the completed surveys lacked site listings or were vague - the Bureau determined that the Quest tool surveyed only 263 sites (operated by the 39 vendors) out of a projected 1,502 sites that DMR projected for survey evaluations. DMR projected that the Quest survey would evaluate the 1,502 separate sites in the first year (1994), according to the DMR's "POS Programmatic Monitoring in the Department of Mental Retardation." **In addition to the low**

number of sites actually visited, some of the QUEST forms lacked the information the survey tool was designed to collect. For example, many of the completed surveys did not indicate whether Criminal Offender Record Inquiry (CORI) checks had been performed for vendor employees. Other surveys lacked required information such as the proper survey and report dates, while others did not include the necessary information in regard to human rights committees and their officers. It was also impossible to verify, from the survey forms provided, which sites were visited or that the appropriate consumer and personnel files had been reviewed. The content of the survey reports also lacked uniformity.

During a DMR presentation senior DMR managers advised the Bureau that the Quest tool is continually undergoing modification. This is in addition to the one year of planning and design that it took to create the Quest survey tool. The time it takes to complete a single survey is also an on-going problem, the Bureau was told.

Continuing Proliferation of Vendors

DMR has approximately 1700 purchase of service contracts with 361 private service providers, according to the "POS Programmatic Monitoring in the Department of Mental Retardation." Contracts include residential, work/day, support, and transportation services. QUEST is used to monitor the quality of services provided by all public and private providers. After a QUEST survey has been completed, DMR awards certification for either one, two years, or with conditions. According to documentation received from DMR, "1,502 separate service sites" were to be visited in the first year of QUEST's implementation. As

mentioned above, with most of the year gone, this goal appears not to have been met. The terms "sites" and "vendors" are different. For example, one vendor can operate similar or distinct programs at multiple sites. DMR told the Bureau that the sampling of DMR clients is designed to guarantee a visit to all sites that a vendor operates. The current tool's effectiveness can only diminish in an environment of vendor proliferation.

Inquiry Regarding Incidents of Abuse and Neglect

The Bureau and the Committee received numerous requests to review and investigate specific incidents of abuse. These requests included problems with investigation practices and general policies at DMR alleged to be detrimental to DMR clients. The Bureau found ample evidence that incidents of abuse were continuing, in some cases were unmonitored, and in other cases were inadequately investigated.

The Bureau's initial review also indicated that the agency continued to make efforts to downplay the incidents and level of abuse and to foster policies which make reporting of abuse difficult and confrontational.

Based upon its initial and preliminary review, the Bureau finds sufficient facts to indicate there are ongoing problems in the investigative division and in vendor oversight. The Bureau's review of vendor contracts, QUEST documents, and documents that relate to licensing issues raised serious concerns about the level of oversight, attention to detail, level of personnel, and the appropriateness of training and monitoring on the part of DMR.

As an example of its contention, the Bureau offers the following case study:

CASE STUDY

In the course of its inquiry into the Department of Mental Retardation's monitoring efforts and investigative procedures, the House Post Audit and Oversight Bureau examined in detail the records related to the drowning of a disabled and retarded client in an in-ground pool at the client's community residence in North Reading. The unused in-ground pool was partially filled with murky, blackish water at the time of the drowning. The Bureau reviewed several investigative reports and interviewed investigators representing several agencies. The Bureau inspected the site, as well as reviewed town building, inspection, and assessing records, medical files, and the autopsy report. Bureau analysts interviewed police, firefighters, and emergency medical personnel who responded to the emergency call and were at the scene shortly after the client's death. Based upon the Bureau's review, the following is noted:

The deceased client was left unattended for 10 minutes on a backyard patio of his community residence by a direct care worker. The direct care worker was attempting to assist a co-worker with three other retarded and disabled clients. These retarded persons also resided at the home. The client made his way to the pool and drowned. The pool was in close proximity to the patio where the client was left alone.

This client had been a ward of the state since infancy. He had a known obsession with water. Through sworn testimony, the Bureau learned that the client, although disabled,

had the ability to "scoot very quickly." A fence restricting access to the home's in-ground pool from all points in the backyard, including the patio, was erected only after the client's death. Prior to the accident the patio and resident access to the pool was customarily restricted by a gas grill. The perimeter of the backyard itself was fenced in.

Both of the deceased client's parents are dead. His only living relative is a sister who is also retarded. In 1959, a brother of the client also died from drowning while residing at the Fernald State School.

One DMR investigator who testified stated that the file did not contain any indication of a pool on site. Additionally, the site feasibility survey tool, which has also been described as the "physical facility" survey tool, had a series of "check-off" boxes for a pool, but those boxes were not marked. Witnesses indicated that the pool was in "deplorable" condition.

One DMR investigator also testified that the vendor did not have an adequate search procedure in effect.

The Bureau's review of this particular case highlights many of the major findings of the Bureau's preliminary report. In the Bureau's opinion the need of careful and copious oversight of private vendors is demonstrated in this case study.

QUEST Follow-up Procedures Lacking

Even in the cases where the survey tool is employed, the extent and ability to conduct a re-examination of deficiencies uncovered by monitoring is unclear. Nor does there appear to be uniformity from survey to survey within the Quest tool itself.

The Bureau has concerns as to whether or not the QUEST tool is successfully monitoring services and ensuring consumer quality of care. Furthermore DMR officials have informed the Bureau that the former licensing process is being performed "the same as before." However, this process is performed by Quality Enhancement Specialists, who are also responsible for carrying out QUEST surveys and the follow-up process.

It also remains unclear how follow-up visits are conducted. It is not clear what remedial action is taken as a result of surveys, or, what documentation results from a follow-up.

In addition, the Bureau was informed that a data analyst was hired recently to assist in computerizing various aspects of the information obtained through the survey process. However, it is not currently possible to generate a listing of facility names and follow-up dates.

Moreover, the Bureau is troubled by the agency's confrontational approach to many aspects of the audit. For example, on two occasions in response to requests to clarify certain information or to ask legitimate questions about documents, the Bureau was confronted with written responses from DMR indicating that it was not DMR's obligation to explain the documents. (Please See Exhibit #1)

Finally, the Bureau believes that the substantial structural changes at DMR from a central to a decentralized system warrant inquiry. The proliferation of community based care providers; coupled with the expanding and decentralized nature of the DMR community

residence system build in monitoring and oversight problems. Moreover, recent news accounts regarding the future reliability of medicaid funding could be disastrous to the state's provider services network. These and other issues make the validity of monitoring measures, follow-up inspections, and investigation of complaints all the more important.

APPENDIX

The Governor's Commission

The Governor's Commission on Mental Retardation - Executive Order No. 356, was established on May 25, 1993. The order established a nine (9) member commission.

Conducting public hearings on the quality, health, well being, and safety of Massachusetts citizens with mental retardation were among the duties of the commission.

In addition, the Commission was empowered to serve as ombudsmen and to resolve disputes about the provision of services. The Commission under article 3.2 was mandated to hold public hearings at least semi-annually. The Commission was also given broad powers and access to all facilities, records, reports and materials in order to enhance their appreciation of the needs of persons with mental retardation. Since its establishment, the Commission has held one hearing on June 28, 1994. The topic of the hearing was a discussion of the long waiting list of disabled citizens trying to secure DMR services. The number of people on the waiting list has increased from 3,236 in June to 3,675 by the end of November. (2,424 individuals who remain unserved and 1,251 individuals who remain underserved) Expressed as a percentage this is an increase of 14 percent in five months; annualized it is an increase of 34 percent. The waiting list continues to be a problem for DMR and families throughout Massachusetts.

The Governor's Commission's next scheduled hearing was November 16, 1994. It had to be cancelled due to the lack of a quorum (of six). Executive Order 371 signed July 19, 1994 reduced the Commissioners' quorum qualification from 7 to 6.

APPENDIX #2

Disabled Persons Protection Commission (DPPC)

In addition to the Governor's Commission, the Disabled Persons Protection Commission (DPPC) is an investigative oversight agency for DMR.

Massachusetts General Law Chapter 19C Section 2 established the Disabled Persons Protection Commission. The purpose of the Commission is "to provide for investigation and remediation of instances of abuse of disabled persons in the Commonwealth." The Commission consists of three members appointed by the Governor, one of whom is designated as the Chairman. From the period January 1, 1994 through April 30, 1994, 88 cases of abuse were received by DPCC. Of the 88 cases examined 22 cases of abuse were substantiated by the Commission. Under the provisions of the "DPPC Investigations Standards", Section B part three, entitled Non-Emergencies; "All non-emergency investigations must be completed within 10 calendar days [and] investigation reports resulting from these cases must be completed within 10 additional working days." DPPC sends a copy of its investigative report to EOHHS and the Commissioner of the agency where the abuse occurred.

EXHIBIT 1

The Commonwealth of Massachusetts
HOUSE POST AUDIT AND OVERSIGHT BUREAU
ROOM 146 STATE HOUSE
BOSTON MA 02133-1053

WILLIAM P. NAGLE, JR
CHAIRMAN COMMITTEE ON
POST AUDIT AND OVERSIGHT

THOMAS W. HAMMOND, JR
DIRECTOR
617-722-2575

October 11, 1994

Kim Murdock
General Counsel
Department of Mental Retardation
160 North Washington Street
Boston, MA 02114

Dear Ms. Murdock:

The House Post Audit and Oversight Bureau (the "Bureau") has requested several pieces of documentation from DMR as part of our ongoing review.

The documentation received refers to the "QUEST" tool, which replaced Quality Assurance and licensing as of January 1, 1994. A memorandum, dated July 5, 1994, from Assistant Commissioner, Office of Quality Enhancement, Mary Cerreto, to Alicia Ellard, stated "Many of the former licensing processes and procedures are still in effect. Notably these are Fire Safety Training, Safety Feasibility Studies, Pre-occupancy Approvals, and any requests for Waivers." Another memorandum, also dated July 5, 1994, from Assistant Commissioner Cerreto to Alicia Ellard, stated; "There are no licensing procedures for Quality Enhancement Staff."

Is the "QUEST" process the only evaluation form and process currently in use by DMR? If so, is the fire safety training, safety feasibility etc., now a part of the QUEST process?

If other evaluation processes are used in addition to "QUEST" what are they? and what are their functions? Please describe, in detail, all other licensing processes used by DMR as of 1/1/94.

If other licensing processes are utilized please provide us with the department responsible for using the licensing process, and a list of staff responsible for this process. If there are forms utilized in this regard please provide us with representative samples.

Please provide the above information by Thursday, October 20, 1994. If you have any questions or concerns please contact Julie Kavanagh, Research Analyst, at 722-2417.

Sincerely,

Thomas W. Hammond, Jr.

The Commonwealth of Massachusetts
Executive Office of Health & Human Services
Department of Mental Retardation
160 North Washington Street
Boston, MA 02114

Philip Campbell
Commissioner

Area Code (617)
727-5608
TDD Line
727-9866

October 17, 1994

Thomas Hammond, Jr., Director
House Post Audit And Oversight Bureau
State House, Room 146
Boston, MA 02133

Dear Mr. Hammond:

I am responding to your letter to Kim Murdock, General Counsel, dated October 11, 1994. In your letter you make several requests for explanations of certain QUEST documents produced by the Department of Mental Retardation in response to the Bureau's subpoena.

To date, the Department continues to forward all documents in response to the Bureau's subpoena as is our legal obligation. In addition, the Department has opened its provider contract files for your staff to review at our office. It is not the Department's responsibility, however, to explain or interpret the documents which the Bureau has requested or reviewed. The Department neither has the time nor staff available to respond to repeated requests for explanations of the documents' contents.

Very truly yours,

Alicia M. Ellard
Assistant General Counsel

cc: Kim Murdock